ALPINE COUNTY
BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan and Evaluation Report

Annual Work Plan for FY 2020/2021 and Evaluation Report for FY 2019/2020

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A. QUALITY IMPROVEMENT PROGRAM OVERVIEW

1. Quality Improvement Program Characteristics

Alpine County Behavioral Health Services (ACBHS) has implemented a Quality Improvement (QI) program in accordance with state regulation for evaluating the appropriateness and quality of mental health services, including overutilization and underutilization of services; timeliness standards; access; and effectiveness of clinical care.

It is the purpose of ACBHS to build a structure that ensures the overall quality of services. The QI program meets this objective through the following processes:

a. Identifying goals and prioritized areas for improvement;
b. Collecting and analyzing data to measure against the identified goals or areas of improvement;
c. Based on data and identified trends, designing and implementing interventions to improve performance;
d. Measuring the effectiveness of the interventions over time; and
e. Incorporating successful interventions across the system, as appropriate.

The ACBHS QI program is designed to address quality improvement and quality management to ensure to all stakeholders that the processes for obtaining services are fair, efficient, and cost-effective; and that they produce results consistent with the belief that people with mental illness may recover. The ACBHS QI program is responsible for monitoring MHP effectiveness through the upkeep and implementation of performance monitoring activities in all levels of the organization, including but not limited to, client and system access; timeliness; quality; clinical outcomes; utilization and clinical records review; monitoring and resolution of client grievances and appeals; fair hearings; provider appeals, and assessment of clients.

The QI program is crucial for upholding and monitoring the requirements of state and federal regulations regarding timeliness and quality of care; the Medi-Cal Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS); the state plan contract with DHCS for the delivery of Drug Medi-Cal (DMC) services; and the contract between ACBHS and DHCS for the delivery of Substance Abuse Prevention and Treatment Block Grant (SABG) services.

Executive management and program leadership is crucial to ensure that QI activities and findings are used to establish and maintain the overall quality of the service delivery system and organizational operations. As a result, the QI program is directly accountable to the ACBHS Director.

2. Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for the conducting key activities of the ACBHS Quality Improvement Program. QIC meetings are held at least quarterly.

a. QIC Responsibilities – The QIC is responsible for the following functions:

1) Implements the specific and detailed review and evaluation activities of the agency.
   - Regularly collects, reviews, evaluates, and analyzes data and implements actions that frequently involve handling sensitive and confidential information.
   - Provides oversight to QI activities, including the development and implementation of the required Performance Improvement Projects (PIPs).
   - Reviews collected information, data, and trends relevant to standards of cultural and linguistic competency.

2) Recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs.
   - Institutes needed actions and ensures follow-up of QI processes.
   - Documents all activities through dated and signed minutes to reflect all QI decisions and actions made by all four CQIC meetings.

3) Ensures that QI activities are completed as required; and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities.
   - Monitors previously-identified issues and related data; and tracks issues and interventions over time.
   - Promotes client and family voice to improve wellness and recovery.
   - Continuously conducts planning and initiates new activities for sustaining improvement.

b. QIC Membership – Designated members of the QIC include the ACBHS Director; Clinical Coordinator; Behavioral Health Services Coordinator; Alcohol and Drug Program Specialist; designated clinical staff; designated administrative staff; and community members, including consumers and family members, as well as MHSA- and AOD-funded agencies. ACBHS contracts with several non-profit groups for outreach and engagement services. As a component of the contracts, these entities are required to attend the quarterly meetings of the QIC.

c. QIC Agenda – The QIC uses a standing meeting agenda to ensure that all required QI components are addressed at each QIC meeting. The agenda includes at least the following:

- Review Access and Information Log
  - Review business days for initial assessment and first service appointments; meds requests

    - Assess response for urgent and crisis conditions (during regular hours and after-hours)
    - Review requests for cultural/linguistic services, including language assistance; assess results
    - Review Access Line Test Calls (quarterly report)
- Review Clinical Team Meeting Assessments (CANS, PSC, etc.)
- Review Inpatient / IMD / Residential programs: census, utilization, and length of stay
- Review processed TARs
- Review medication monitoring/med chart review process
- Review grievances and appeals (client or provider), including change of provider requests
- Review NOABDs
- Review requests for (or results of) state fair hearings; requests for aid paid pending
- Conduct chart reviews
    - Monitor UR return for Review and Correction process through summary format
    - Review EHR process for quality assurance
    - Follow up on any required Corrective Action Plans (CAPs)
- Assess client and family satisfaction surveys
- Review Performance Improvement Projects (PIPs); progress; and related data
- Review data for client- and system-level performance outcome measures
- Review results of Medi-Cal service verification process
- Review compliance; fraud/waste; patient's rights; and HIPAA/privacy issues
- Review county and contract provider certification/recertification status; credentialing
- Review new regulations and standards, including DHCS notices and publications
- Review and update SMHS Implementation Plan, as necessary (annually)
- Review provider satisfaction surveys, as necessary (annually)
- Review results of audits and other reviews (Triennial; EQR; SUD)
- Discuss consumer participation in services, system planning, QIC, etc.
- Other items for discussion
- Recommend identified program changes; assign new action items

d. QIC Meeting Sign-In Sheet – A Sign-In Sheet is collected at the beginning of each QIC meeting.
    - A Confidentiality Statement is integrated into the QIC sign-in sheet and ensures the privacy of protected health information.

e. QIC Meeting Minutes – The QIC uses a meeting minute template to ensure that all relevant and required components are addressed in each set of minutes.
    - Meeting minutes are utilized to track action items and completion dates.
    - Minutes are maintained by the Behavioral Health Services Coordinator or designee, and are available for required annual audits and triennial reviews.

3. Behavioral Health Board

The Behavioral Health Board (BHB) meets at least six (6) times annually. The members of the BHB include appointed consumers; representative from the Alpine County Board of Supervisors; ACBHS Director; QI Staff and support staff. The BHB receives information from the QIC and provides feedback on access findings and policy change proposals. The comments from this forum are documented in the meeting minutes and reported back to the QIC to finalize and policy changes. A QIC member regularly presents information to the BHB to ensure that quality issues are discussed.

4. Quality Improvement Annual Work Plan Components

The Annual Work Plan for Quality Improvement activities of ACBHS provides the blueprint for the quality management functions designed to improve both client access and quality of care. This Plan is evaluated annually and updated as necessary.

The ACBHS annual QI Work Plan includes at least the following components:

a. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;
b. A determination of objectives and goals for the coming year;
c. Tracking previously-identified issues over time through data analysis; and
d. Outlining activities and interventions for improving identified issues and sustaining quality of care.

The ACBHS Behavioral Health Services Coordinator facilitates the implementation of the QI Work Plan and the QI activities. Sufficient time to engage in QI activities will be allocated to this position (e.g., conducting chart reviews, coordinating Performance Improvement Projects, facilitating the committee, monitoring activities).

The QI Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Improvement program. QIC members participate in the planning, design, and implementation of the QI program, including policy setting and program planning. The ACBHS QI Work Plan addresses quality assurance/improvement factors as related to the delivery of timely, effective, and culturally-competent specialty mental health services.

The QI Work Plan is posted on the ACBHS website, and is also available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the ACBHS system. The QI Work Plan is also available to auditors during the triennial Medi-Cal reviews.

5. Accountability

The QIC is accountable to the ACBHS Director. The QI program coordinates performance monitoring activities throughout the program and includes client and system level outcomes, implementation and review of the utilization review process, credentialing of licensed staff, monitoring and resolution of beneficiary grievances, fair hearings, and provider appeals, periodically assessing consumer, youth, and family satisfaction, and reviewing clinical records.

ACBHS contracts with Kings View for telepsychiatry outpatient care, and with hospitals in the region and state for inpatient services. As a component of the contracts, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by state and federal regulations.

B. DATA COLLECTION – SOURCES AND ANALYSIS

1. Data Collection Sources

   Data sources and types may include, but not are limited to, the following (as available):

   - Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ
   - Electronic Health Record (EHR) reports
   - Access and Information Log (initial contact log)
   - Test call logs
   - Client and family satisfaction surveys
   - Client Grievance/Appeal logs; State Fair Hearing logs
   - Change of Provider forms and logs
   - Medication Chart Review forms and logs
   - Staff training logs
   - Notice of Adverse Benefit Determination (NOABD) forms and logs
   - Second Opinion requests and outcomes
   - Treatment Authorization Requests (TAR) and Inpatient logs
   - Service Authorization Request (SAR) logs
   - Staff productivity reports
   - Chart Review Checklists (and any corrective action plans [CAPs])
   - Compliance logs
   - Policies and procedures
   - QIC and other meeting minutes
   - EQR and Medi-Cal Audit results
   - Special reports from DHCS or other required studies

2. Data Analysis and Interventions

    a. The Behavioral Health Services Coordinator performs preliminary analysis of data to review for accuracy and completion.
        - If there are areas of concern, the QIC discusses the information. Clinical staff may be asked to implement CAPs, as needed.
        - Policy changes may also be implemented, if required.
        - Subsequent review is performed by the QIC.

    b. The changes to programs and/or interventions are discussed with individual staff; QIC members (including consumers and family members); Behavioral Health Board members; and management.

    c. Program changes have the approval of the ACBHS Director and/or the Clinical Coordinator prior to implementation.

    d. Effectiveness of program changes are evaluated by the QIC.
        - Input from QIC is documented in the meeting minutes, which include the activity, person responsible, and timeframe for completion.
        - Each activity and the status for follow-up are discussed at the beginning of the next meeting.

C. DELEGATED ACTIVITIES STATEMENT

ACBHS does not delegate any review activities. Should delegation take place in the future, this Plan will be amended accordingly.

D. QI EVALUATION REPORT – ACTIVITIES, DATA, AND INTERVENTIONS

Goal 1: To ensure timely access to routine outpatient services, persons requesting non-crisis mental health services who are new to ACBH, are offered an initial assessment appointment within ten (10) business days of the request for services			
Objective	To monitor timeliness of new requests for routine outpatient mental health services to ensure accessibility		
Numerator	Total number of persons requesting mental health services who are new to ACBH and were offered an initial assessment appointment within 10 business days in a given fiscal year		
Denominator	Total number of persons requesting mental health services who are new to ACBH mental health services in a given fiscal year		
Performance Indicator/Target Goal	To offer an initial assessment appointment within 10 business days of request		
Data	Number and percent of new requests who met this standard in FY 2017-2018	54 of 55 clients	98.2%
	Number and percent of new requests who met this standard in FY 2018-2019	70 of 73 clients	95.9%
	Number and percent of new requests who met this standard in FY 2019-2020	58 of 60 clients	96.7%
Evaluation			
Analysis: The percent of persons requesting mental health services who are new to ACBHS and were offered an assessment appointment within 10 days has remained high across the past three (3) fiscal years. There was a slight decrease in the percentage from FY 2017-2018 to FY 2018-2019, with an increase in FY 2019-2020.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will maintain and/or improve the percent of requests that are offered an initial assessment appointment within 10 business days.			
Planned Interventions: • Offer staff training on scheduling new requests for services, with an emphasis on the 10-day standard • Provide feedback to staff at monthly staff meetings on the percent of requests that were offered within 10 business days (review A&I Log) • Review staff schedules and block assessment times each week to allow admin staff to schedule appointments within 10 business days			

Data Source: Access and Information Log
Frequency: Quarterly

Goal 2: To increase the number of outpatient mental health services received by Transition Age Youth (TAY)		
Objective	To offer TAY engaging outpatient mental health services to increase TAY utilization of services and ACBHS service delivery capacity	
Numerator	Total number of outpatient mental health services delivered to TAY in a given fiscal year	
Denominator	Total number of TAY clients served in a given fiscal year	
Performance Indicator/Target Goal	To increase to the number of outpatient mental health services received by TAY to at least 10 mental health services per TAY client each year	
Data	Average number of outpatient mental health services received by TAY clients in FY 2017-2018	4 services
	Average number of outpatient mental health services received by TAY clients in FY 2018-2019	7 services
	Average number of outpatient mental health services received by TAY clients in FY 2019-2020	10 services
Evaluation		
Analysis: The average number of outpatient mental health services received by TAY has increased over the past three (3) fiscal years.		
Quality Improvement Action Plan: In FY 20/21, ACBHS will maintain and/or increase the number of outpatient mental health services received by TAY, providing at least 10 mental health services per TAY client in the fiscal year.		
Planned Interventions: • Offer staff training on designing services that help engage TAY in services • Hold TAY focus groups at least quarterly to generate ideas for TAY activities • Identify and deliver engaging TAY activities such as hiking, snow sports, weekend trips to regional events, etc. • Identify TAY activities for TAY and families to create positive experiences (e.g., bowling; evening hiking; picnics; Karaoke) • Develop Peer Mentor positions (0.5 FTEs) to help engage TAY and create engaging TAY activities		

Data Source: Cerner
Frequency: Annually

Goal 3: To ensure timely access to a Medication Assessment			
Objective	To monitor timeliness of new referrals to a medication assessment through Telepsychiatry to ensure access to medication services		
Numerator	Total number of persons referred for a medication assessment who receive a Telepsychiatry medication assessment service within 15 business days.		
Denominator	Total number of persons referred for a medication assessment to Telepsychiatry.		
Performance Indicator/Target Goal	To ensure clients who need to be assessed for medications receive a medication assessment within 15 business days.		
Data	Number of clients who received a medication assessment within 15 business days in FY 2017-2018.	5 of 7 clients	71.4%
	Number of clients who received a medication assessment in within 15 business days in FY 2018-2019.	3 of 7 clients	42.9%
	Number of clients who received a medication assessment in within 15 business days in FY 2019-2020.	2 of 6 clients	33.3%
Evaluation			
Analysis: The percent of mental health clients who were referred for a medication assessment and received a medication assessment service has varied across the years. There are a small number of new clients who are referred for medication assessment each year; therefore, there is variability in the number of persons who receive a medication assessment through Telepsychiatry. There are also a limited number of hours of Telepsychiatry available in Alpine County, which limits the days that are available to schedule clients for an assessment.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will work closely with Kings View to increase the number of medication assessment appointments and to improve access to this level of care.			
Planned Interventions: • Ensure that the contract with Kings View has adequate access to a Telepsychiatrist to schedule medication assessments within 15 business days • Provide feedback to Kings View about length of time to schedule a Telepsychiatry assessment appointment • Offer transportation to clients to help them keep their medication assessment appointment, as scheduled			

Data Source: Cerner
Frequency: Annually

Goal 4: To ensure timely access to outpatient mental health services, persons requesting mental health services receive a first service within ten (10) business days of the Assessment			
Objective	Ensure that persons receive a first service within 10 business days of the Assessment		
Numerator	Total number of persons requesting outpatient mental health services who receive a first service within 10 business days of the Assessment in a given fiscal year		
Denominator	Total number of clients requesting outpatient mental health services who received an Assessment in a fiscal year		
Performance Indicator/Target Goal	To receive an outpatient mental health service within 10 business days of the Assessment		
Data	Number and percent of services that met this standard in FY 2017-2018	Not available; analysis began in FY 2018-2019	
	Number and percent of services that met this standard in FY 2018-2019	14 out of 23	60.9% met goal
	Number and percent of services that met this standard in FY 2019-2020	15 out of 27	55.6% met goal
Evaluation			
Analysis: This indicator was new in FY 18/19. Across the two (2) fiscal years for which there is data, the number and percent of services that met the 10-day standard slightly declined.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will improve the capacity to ensure that persons receive a first service within 10 business days of the Assessment.			
Planned Interventions: • Offer staff training on scheduling services within the 10-day standard • Instruct Admin staff to call the client the day before a scheduled service appointment, to remind the client of the appointment • Provide feedback to staff at monthly staff meetings on the percent of persons who received a first service within 10 business days (review A&I Log)			

Data Source: Access and Information Log**;** Cerner
Frequency: Annually

Goal 5: To increase access to the Full-Service Partnership (FSP) program for clients of all ages			
Objective	To increase the number and percent of clients who are enrolled in the FSP program to help improve health, wellness, and recovery.		
Numerator	Number of FSP mental health clients served in a given fiscal year		
Denominator	Total number of all mental health clients served in a given fiscal year		
Performance Indicator/Target Goal	To increase the number of clients who are enrolled in the Full-Service Partnership (FSP) program		
Data	Number and percent of FSP clients in FY 2017-2018	5 of 84 clients	6.0%
	Number and percent of FSP clients in FY 2018-2019	3 of 88 clients	3.4%
	Number and percent of FSP clients in FY 2019-2020	2 of 71 clients	2.8%
Evaluation			
Analysis: The percent of mental health clients who are FSP has decreased over the past three (3) fiscal years. This decrease was due to FSP clients moving out of the county or being determined to no longer meet FSP criteria. In this very small county, changes in client status can have a significant impact on the client base, especially in a program as specific as FSP.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will work to increase the number of persons who are designated as Full Service Partnership (FSP) enrollment.			
Planned Interventions: • Provide ongoing training to staff to assess all clients for FSP eligibility • Train staff around FSP services, case management, and use of flex funds • Identify and enroll clients who could benefit from FSP services • Provide feedback to staff at monthly staff meetings on the number and percent of persons who are identified as FSP and discuss the types of activities that have helped improve health, wellness, and recovery. Discuss other clients who could benefit from FSP services.			

Data Source: Cerner
Frequency: Quarterly

Goal 6: Increase the number of clients responding to the POQI surveys by 25%			
Objective	To obtain feedback regarding access and quality of services from individuals receiving services by administering the POQI surveys.		
Numerator	Number of clients who completed a POQI survey in a given fiscal year		
Denominator	Number of clients who received services in a given fiscal year		
Performance Indicator/Target Goal	Increase the number and percent of clients who complete the DHCS POQI instruments by 25% across the 2 administrations annually		
Data	Number of clients who complete the DHCS POQI in FY 2017-2018	4 respondents	0% increase/decrease over previous
	Number of clients who complete the DHCS POQI in FY 2018-2019	4 respondents	0% increase/decrease over previous
	Number of clients who complete the DHCS POQI in FY 2019-2020	10 respondents	150% increase/decrease over previous
Evaluation			
Analysis: The number of clients who complete the POQI survey significantly increased in FY 2019-2020.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will maintain and/or increase the number of clients who complete the DHCS POQI instruments, across the 2 administrations annually.			
Planned Interventions: • Continue to train staff to collect the POQI from each client receiving services in the two week time period • Hire a consumer or family member to offer to assist the client to complete the survey • Have a competition across staff to reward the person who collects the most surveys • Offer clients an incentive for completing the survey			

Data Source: Completed POQI surveys
Frequency: Twice each year, totaled annually

Goal 7: Resolve, and respond in writing to, 100% of all filed grievances, within 60 calendar days			
Objective	To evaluate client grievances, appeals, and requests for state fair hearings, to ensure access and quality of care		
Numerator	Number of grievances that were resolved, and client and provider notified in writing, within 60 calendar days of receipt in a given fiscal year		
Denominator	Total number of grievances in a given fiscal year		
Performance Indicator/Target Goal	100% of filed grievances are resolved, and client and provider notified in writing, within 60 calendar days of receipt		
Data	Number of grievances and percent that met standard in FY 2017-2018	0 filed	N/A
	Number of grievances and percent that met standard in FY 2018-2019	0 filed	N/A
	Number of grievances and percent that met standard in FY 2019-2020	1 filed 0 resolved on time	0%
Evaluation			
Analysis: There remains a low number of grievances filed year to year with ACBHS. In FY 19/20, one (1) grievance was filed, but was not resolved within 60 calendar days.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will resolve 100% of filed grievances, and notify client and provider in writing, within 60 calendar days of receipt.			
Planned Interventions: • Provide staff training on grievances, appeals, and state fair hearings and how to document and resolve each event • Review grievances, appeal, and state fair hearings during QIC to evaluate services and develop strategies for improving services			

Data Source: Grievance and Appeal Log
Frequency: Quarterly

Goal 8: To deliver services that are culturally sensitive to each client's cultural/ethnic background and in their preferred language			
Objective	To ensure staff deliver services that are culturally and linguistically sensitive to help improve access and quality of care		
Numerator	Number of respondents who agreed to the POQI survey question: "Staff were sensitive to my cultural/ethnic background" in a given fiscal year		
Denominator	Total number of respondents who completed the POQI survey		
Performance Indicator/Target Goal	To increase and/or sustain the number and percent of POQI respondents who report to the survey question: "Staff were sensitive to my cultural/ethnic background"		
Data	Number and percent of respondents who report that staff met this measure in FY 2017-2018	2 out of 4	50.0%
	Number and percent of respondents who report that staff met this measure in FY 2018-2019	4 out of 4	100.0%
	Number and percent of respondents who report that staff met this measure in FY 2019-2020	8 out of 9	88.9%
Evaluation			
Analysis: The percent of POQI survey respondents who reported staff sensitivity to their cultural/ethnic background increased in FY 2018-2019; and then decreased in FY 2019-2020.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will increase the number and percent of clients and family members who report to the survey question: "Staff were sensitive to my cultural/ethnic background."			
Suggested Interventions: • Provide training to staff on cultural humility • Provide training to staff on areas for providing culturally-relevant services to each of the primary cultural groups in the county (e.g., American Indian; Hispanic) • Invite members of each culture to provide training on how to improve services and create more culturally appropriate services • Assess the number of staff who represent each of the primary cultures and languages in the county and identify cultures and languages that are underrepresented • Develop strategies for hiring individuals to strengthen the diversity of staff			

Data Source: Completed POQI surveys
Frequency: Twice each year, totaled annually

Goal 9: To conduct medication monitoring activities on at least 10% of medication charts each year			
Objective	To assess the safety and effectiveness of medication practices in ACBH to ensure quality of care		
Numerator	Number of medication charts reviewed in a given fiscal year		
Denominator	Total number of persons receiving medication services in a given fiscal year		
Performance Indicator/Target Goal	To increase the number of medication charts reviewed through medication monitoring to represent 10% the persons receiving medication services.		
Data	Number and percent of medication charts reviewed in FY 2017-2018	1 chart	4%
	Number and percent of medication charts reviewed in FY 2018-2019	13 charts	59%
	Number and percent of medication charts reviewed in FY 2019-2020	7 charts	37%
Evaluation			
Analysis: The percent of medication charts reviewed was very low in FY 2017-2018 (4%). This percent increased to 59% in FY 2018-2019; and then decreased in FY 2019-2020 (37%). There is great variability in this data due to the small number of medication charts; and the ability of ACBHS to maintain a contract with a third-party prescriber.			
Quality Improvement Action Plan: In FY 19/20, ACBHS will increase the number of medication charts reviewed through medication monitoring to 10% of all medication charts to ensure quality of care.			
Suggested Interventions: • Provide staff training on the importance of medication monitoring • Contract with a psychiatrist or pharmacist to complete medication monitoring at least quarterly • Review medication monitoring results at QIC at least quarterly			

Data Source: Cerner
Frequency: Annually

Goal 10: To ensure that clients are involved in the development of their Treatment Plans			
Objective	To ensure that clients are actively involved in the development of their Treatment Plans to ensure active participation in services and improve quality of care		
Numerator	Number of treatment plans that were signed by the client in a given fiscal year		
Denominator	Total number of treatment plans written in a given fiscal year		
Performance Indicator/Target Goal	To have 100% of Treatment Plans signed by the client		
Data	Number and percent of treatment plans that were signed by the client in FY 2017-2018	48	98%
	Number and percent of treatment plans that were signed by the client in FY 2018-2019	53	100%
	Number and percent of treatment plans that were signed by the client in FY 2019-2020	66	100%
Evaluation			
Analysis: The percent of completed Treatment Plans that were signed by the client has remained 100%, or close to 100%, since FY 2017-2018.			
Quality Improvement Action Plan: In FY 20/21, ACBHS will continue to ensure that 100% of Treatment Plans are signed by the client.			
Suggested Interventions: • Provide training to staff and clients on the importance of clients being actively involved in the development of their treatment goals and as indicated by the client signing their Treatment Plan • Provide training to staff and clients on how to identify goals for treatment • Review documentation for Treatment Plans at QIC on a quarterly basis			

Data Source: Cerner
Frequency: Quarterly

Goal 11: To increase staff productivity, including the percent of billable services, to improve access, quality, and cost-effectiveness of services.		
Objective	To assess and monitor staff productivity to improve access, staff performance, effective service utilization, service capacity, and cost-effectiveness of services	
Numerator	Number of services delivered by staff that were billable services in a given fiscal year	
Denominator	Total number of services delivered by staff in a given fiscal year	
Performance Indicator/Target Goal	To improve the number and percent of billable services delivered by staff each year	
Data	Percent of services delivered by staff that were billable services in FY 2017-2018	37%
	Percent of services delivered by staff that were billable services in FY 2018-2019	62%
	Percent of services delivered by staff that were billable services in FY 2019-2020	85%
Evaluation		
Analysis: The percent of services delivered by staff that are billable increased from 37% (Fiscal Year 2017-2018)to 62% (FY 2018-2019). In FY 2019-2020, this percent greatly increased to 85%.		
Quality Improvement Action Plan: In FY 2020-2021, ACBHS will maintain or increase the percent of billable services delivered by staff.		
Suggested Interventions: • Provide training to staff on documentation of services and identify opportunities to maximize the number of billable services • Review productivity on a quarterly basis at QIC, identify any issues with compliance, as appropriate • Provide feedback to staff on productivity and celebrate successes		

Data Source: Cerner
Frequency: Quarterly